		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044750

Facility Name: Community Nursing & Rehabilitation Center

Address: 1136 North Mill Street (Number) Naperville (City) 60563 (Zip Code)

County: DuPage

Telephone Number: (630) 355-3300 **Fax #** (630) 355-1417

IDPA ID Number: 364345878001

Date of Initial License for Current Owners: 04/01/2000

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine Hanover **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 04/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	48	Skilled (SNF)	48	13,200	1
2		Skilled Pediatric (SNF/PED)			2
3	105	Intermediate (ICF)	105	28,875	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	153	TOTALS	153	42,075	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,770		2,312	5,082	8
9	SNF/PED					9
10	ICF	12,638	3,743		16,381	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,408	3,743	2,312	21,463	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.01%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 04/01/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 04/01/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 48 and days of care provided 1,554

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	184,601	23,385	4,206	212,192		212,192		212,192			1
2	Food Purchase		115,078		115,078		115,078	(260)	114,818			2
3	Housekeeping	99,053	14,672		113,725		113,725		113,725			3
4	Laundry	22,508	8,016		30,524		30,524	92	30,616			4
5	Heat and Other Utilities			80,249	80,249		80,249		80,249			5
6	Maintenance	40,516		70,513	111,029		111,029	18,110	129,139			6
7	Other (specify):*											7
8	**TOTAL General Services**	346,678	161,151	154,968	662,797		662,797	17,942	680,739			8
	B. Health Care and Programs											
9	Medical Director			11,700	11,700		11,700		11,700			9
10	Nursing and Medical Records	1,367,543	67,606	1,506	1,436,655		1,436,655		1,436,655			10
10a	Therapy	10,099		47,055	57,154		57,154		57,154			10a
11	Activities	48,933		5,955	54,888		54,888		54,888			11
12	Social Services	19,684		1,091	20,775		20,775		20,775			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,446,259	67,606	67,307	1,581,172		1,581,172		1,581,172			16
	C. General Administration											
17	Administrative	19,808		95,748	115,556		115,556		115,556			17
18	Directors Fees											18
19	Professional Services			41,016	41,016		41,016		41,016			19
20	Dues, Fees, Subscriptions & Promotions			16,319	16,319		16,319	(410)	15,909			20
21	Clerical & General Office Expenses	134,165	15,841	33,132	183,138		183,138	(3,867)	179,271			21
22	Employee Benefits & Payroll Taxes			355,970	355,970		355,970		355,970			22
23	Inservice Training & Education			1,595	1,595		1,595		1,595			23
24	Travel and Seminar			1,093	1,093		1,093		1,093			24
25	Other Admin. Staff Transportation			694	694		694		694			25
26	Insurance-Prop.Liab.Malpractice			86,149	86,149		86,149		86,149			26
27	Other (specify):*											27
28	**TOTAL General Administration**	153,973	15,841	631,716	801,530		801,530	(4,277)	797,253			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,946,910	244,598	853,991	3,045,499		3,045,499	13,665	3,059,164			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Community Nursing & Rehabilitation Center #0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7 **	8	9	10	
30	Depreciation			75,671	75,671		75,671	77,535	153,206			30
31	Amortization of Pre-Op. & Org.			450	450		450		450			31
32	Interest			22,742	22,742		22,742	342,550	365,292			32
33	Real Estate Taxes							74,997	74,997			33
34	Rent-Facility & Grounds			493,835	493,835		493,835	(493,835)				34
35	Rent-Equipment & Vehicles			31,314	31,314		31,314		31,314			35
36	Other (specify):*											36
37	**TOTAL Ownership**			624,012	624,012		624,012	1,247	625,259			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,200		50,200		50,200		50,200			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,829	62,829		62,829		62,829			42
43	Other (specify):* Nonallowable costs			43,060	43,060		43,060	(43,060)				43
44	**TOTAL Special Cost Centers**		50,200	105,889	156,089		156,089	(43,060)	113,029			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,946,910	294,798	1,583,892	3,825,600		3,825,600	(28,148)	3,797,452			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(260)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	92	4		8
9	Non-Straightline Depreciation	(926)	30		9
10	Interest and Other Investment Income	(8,406)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(399)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,350)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(38,311)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule 5A	13,160			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (39,400)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	11,252		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 11,252		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (28,148)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

COMMUNITY NURSING & REHABILITATION CENTER, LLC
FACILITY # 0044750
DECEMBER 31,2000

SCHEDULE 5A

Schedule VI. Part A - Adjustment Detail, Line 29

Non-allowable Expenses	Amount	Reference
Deferred Painting and Decorating	18,110	6
Chamber of Commerce Dues	(525)	20
Offset Miscellaneous Income	(4,340)	21
PAC Dues	(85)	20
Total Non-allowable Expenses	13,160	

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5A

Community Nursing & Rehabilitation Center

ID# 0044750

Report Period Beginning: 04/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark and Chana Weldler	29.50%			Community Nursing &		
Steve and Bluma Jeremias	29.50%	Wheaton Care Center	Wheaton	Rehabilitation Realty,		
Malka Mermelstein	0.50%	Lakefront Healthcare Center, Inc.	Chicago	LLC	Naperville	Real Estate
Herman Mermelstein	0.50%					
Joseph Neumann	30.00%					
Hirsch Wolf	10.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	20	Licenses and Permits		Community Nursing & Rehabilitation Realty, LLC	100.00%	200	200	1
2	V	21	Bank Charges		Community Nursing & Rehabilitation Realty, LLC	100.00%	473	473	2
3	V	30	Depreciation		Community Nursing & Rehabilitation Realty, LLC	100.00%	78,461	78,461	3
4	V	32	Amortization of Mortgage Costs		Community Nursing & Rehabilitation Realty, LLC	100.00%	8,055	8,055	4
5	V	32	Interest Expense		Community Nursing & Rehabilitation Realty, LLC	100.00%	342,901	342,901	5
6	V	33	Property Taxes		Community Nursing & Rehabilitation Realty, LLC	100.00%	74,997	74,997	6
7	V	34	Rent Expense	493,835	Community Nursing & Rehabilitation Realty, LLC	100.00%		(493,835)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 493,835			$ 505,087	$ * 11,252	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Steve Jeremias	Owner	Administrative	29.50%	None	40	100%	Members' Payments	$ 51,094	L17, C3	1
2	Mark Weldler	Owner	Administrative	29.50%	25,090	40	100%	Members' Payments	44,654	L17, C3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 95,748		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7				N/A						7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	American National Bank		X	Mortgage	$18,750.00	03/31/00	$ 4,500,000	$ 4,500,000	03/31/05	Prime+.5	$ 342,901	1
2	American National Bank		X	Improvements	Interest Only	3/31/00	500,000	219,904	03/31/05	Prime+.5	3,968	2
3												3
4												4
5												5
	Working Capital											
6	American National Bank		X	Working Capital	Interest Only	03/31/00	1,500,000	871,000	03/31/01	Prime+.5	18,774	6
7												7
8												8
9	TOTAL Facility Related				$18,750.00		$ 6,500,000	$ 5,590,904			$ 365,643	9
	B. Non-Facility Related*											
10								Amortization of Mortgage Costs			8,055	10
11								Offset Interest Income			(8,406)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (351)	14
15	TOTALS (line 9+line14)						$ 6,500,000	$ 5,590,904			$ 365,292	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 95,684	2
3. Under or (over) accrual (line 2 minus line 1).		$ 95,684	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ *** 94,398	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ * (115,085)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 74,997	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995		8
	1996		9
	1997		10
	1998		11
	1999	** 95,684	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

* Represents monies received at closing from the prior owners for estimated 1999 and 2000 (1/1/00-3/31/00) real estate taxes to be paid by the current owners.

** Represents 1999 real estate taxes paid by the current owners with monies received at closing.

*** Represents estimated 2000 (4/1/00-12/31/00) real estate taxes and monies received at closing for estimated 2000 (1/1/00-3/31/00) real estate taxes

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,087 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [x] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 3,000
2. Number of Years Over Which it is Being Amortized: 5 Years
3. Current Period Amortization: 450
4. Dates Incurred: 04/01/00

Nature of Costs: Mortgage Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	164,335	2000	$ 453,622	1
2					2
3	TOTALS	164,335		$ 453,622	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	153		2000	1986	$ 4,184,589	$	40	$ 78,461	$ 78,461	$ 78,461	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Cable			2000	4,305	81	40	81		81	9
10	Elevator Door			2000	4,389	73	40	73		73	10
11	Parking Lot			2000	38,200	637	40	637		637	11
12	Landscaping			2000	8,736	127	40	127		127	12
13	Sign			2000	4,541	66	40	66		66	13
14	Architect Fees			2000	3,060	57	40	57		57	14
15	Door Lock			2000	2,248	33	40	33		33	15
16	Closets			2000	7,729	80	40	80		80	16
17	Cove Base			2000	4,459	28	40	28		28	17
18	Handrails and Kickplates			2000	15,146	95	40	95		95	18
19	Lighting			2000	65,796	411	40	411		411	19
20	Tile			2000	2,317	14	40	14		14	20
21	Flooring			2000	16,378	53	40	53		53	21
22	Exit Doors			2000	1,598	10	40	10		10	22
23	Window and Cubicle Treatments			2000	34,021	213	40	213		213	23
24	Lighting			2000	1,729	11	40	11		11	24
25	Carpeting			2000	27,139	170	40	170		170	25
26	Fire Panel			2000	4,500	28	40	28		28	26
27	Nurse's Station			2000	8,913	37	40	37		37	27
28	Door Handles			2000	1,644	7	40	7		7	28
29	Cubicle Track			2000	915	2	40	2		2	29
30	Motor			2000	13,276	166	40	166		166	30
31	Stove Hoods			2000	1,429	3	40	3		3	31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 4,457,057	$ 2,402		$ 80,863	$ 78,461	$ 80,863	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$	$	$	$		$	37
38	Current Year Purchases	953,081	71,855	71,855		3-10 yrs	71,855	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 953,081	$ 71,855	$ 71,855	$		$ 71,855	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility	1988 Ford Econoline Bus	2000	$ 3,255	$ 488	$ 488	$	5	$ 488	42
43										43
44										44
45										45
46	TOTALS			$ 3,255	$ 488	$ 488	$		$ 488	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 5,867,015	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 74,745	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 153,206	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 78,461	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 153,206	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 25,524 Description: Computers $11,008; Suction Machine $9,580; Pulse Oximeter $4,936
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	1999 Acura	$ 579.00	$ 5,790	17
18					18
19					19
20					20
21	TOTAL		$ 579.00	$ 5,790	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [x] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10a, C 1, 3	39 hrs	$ 899	1,109	$ 18,372	$	1,148	$ 19,271	1
2	Licensed Speech and Language Development Therapist	L 10a, C 3	hrs		200	2,875		200	2,875	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10a, C 1, 3	368 hrs	9,200	1,244	25,808		1,612	35,008	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				50,200		50,200	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 10,099	2,553	$ 47,055	$ 50,200	2,960	$ 107,354	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 18,196	$ 23,622	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	1,127,076	1,127,076	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,709	66,709	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,211,981	$ 1,217,407	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		453,622	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	381,131	4,457,057	15
16	Equipment, at Historical Cost	956,336	956,336	16
17	Accumulated Depreciation (book methods)	(75,670)	(153,206)	17
18	Deferred Charges		90,553	18
19	Organization & Pre-Operating Costs	3,000	3,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(450)	(8,505)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): Mortgage Costs		53,702	22
23	Other(specify): See attached Schedule 17A	13,495	13,495	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,277,842	$ 5,866,054	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,489,823	$ 7,083,461	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 410,465	$ 410,465	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	871,000	1,039,750	29
30	Accrued Salaries Payable	104,582	104,582	30
31	Accrued Taxes Payable (excluding real estate taxes)	43,539	43,539	31
32	Accrued Real Estate Taxes(Sch.IX-B)		94,398	32
33	Accrued Interest Payable		38,750	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule 17A	278,027	166,954	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,707,613	$ 1,898,438	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	219,904	4,551,154	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 219,904	$ 4,551,154	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,927,517	$ 6,449,592	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 562,306	$ 633,869	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,489,823	$ 7,083,461	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

COMMUNITY NURSING & REHABILITATION CENTER, LLC
FACILITY # 0044750
DECEMBER 31,2000

SCHEDULE 17 A

Schedule XV. Balance Sheet Part B. Line 23

	Operating	After Consolidation
Deposits	13,495	13,495
Total	13,495	13,495

Schedule XV. Balance Sheet Part C. Line 36

	Operating	After Consolidation
Wage Garnishment	383	383
401K Liability	14,628	14,628
Accrued Assessment Fee	772	772
Due To State	24,591	24,591
Due To Patient Trust Fund	20,513	20,513
Due to Prior Owner	106,097	106,097
Refund - Due To Private	5,448	5,448
Refund - Due To Person	(2,717)	(2,717)
Due/Third Party Payor	(2,761)	(2,761)
Due To/From CNRR	111,073	0
Total	278,027	166,954

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(837,694)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Members' Capital Contributed**	1,400,000	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 562,306	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 562,306	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,917,505	1
2	Discounts and Allowances for all Levels	(242,130)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,675,375	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	142,142	6
7	Oxygen	6,890	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 149,032	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	600	13
14	Non-Patient Meals	260	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	100,795	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,214	20
21	Other Medical Services	47,884	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 150,753	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,406	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,406	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	4,340	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,340	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,987,906	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	662,797	31
32	Health Care	1,581,172	32
33	General Administration	801,530	33
	B. Capital Expense		
34	Ownership	624,012	34
	C. Ancillary Expense		
35	Special Cost Centers	93,260	35
36	Provider Participation Fee	62,829	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,825,600	40
41	**Income before Income Taxes (line 30 minus line 40)****	(837,694)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (837,694)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. This entity is a cash basis tax payer.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,408	1,464	$ 47,223	$ 32.26	1
2	Assistant Director of Nursing	1,725	1,829	32,838	17.95	2
3	Registered Nurses	15,687	16,278	359,264	22.07	3
4	Licensed Practical Nurses	9,009	9,302	194,041	20.86	4
5	Nurse Aides & Orderlies	39,742	41,508	621,364	14.97	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	407	407	10,099	24.81	7
8	Rehab/Therapy Aides	1,537	1,650	25,996	15.76	8
9	Activity Director	1,176	1,284	18,132	14.12	9
10	Activity Assistants	3,091	3,207	30,801	9.60	10
11	Social Service Workers	1,096	1,096	19,684	17.96	11
12	Dietician	2,875	2,994	38,301	12.79	12
13	Food Service Supervisor	1,376	1,464	28,563	19.51	13
14	Head Cook	5,023	5,179	56,726	10.95	14
15	Cook Helpers/Assistants	6,051	6,296	61,011	9.69	15
16	Dishwashers					16
17	Maintenance Workers	2,536	2,702	40,516	14.99	17
18	Housekeepers	11,555	11,979	99,053	8.27	18
19	Laundry	2,762	2,836	22,508	7.94	19
20	Administrator	584	624	19,808	31.74	20
21	Assistant Administrator					21
22	Other Administrative	4,452	4,731	102,139	21.59	22
23	Office Manager					23
24	Clerical	2,619	2,675	32,026	11.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,090	2,270	18,067	7.96	31
32	Other Health Care(specify) See Sch. 20A	3,966	4,233	68,750	16.24	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	120,767	126,008	$ 1,946,910 *	$ 15.45	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	109	$ 4,206	L 1, C 3	35
36	Medical Director	Monthly	11,700	L 9, C 3	36
37	Medical Records Consultant	Monthly	586	L 10, C 3	37
38	Nurse Consultant	Monthly	230	L 10, C 3	38
39	Pharmacist Consultant	Monthly	690	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,159	L 11, C 3	44
45	Social Service Consultant	Monthly	1,091	L 12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	109	$ 19,662		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

COMMUNITY NURSING & REHABILITATION CENTER, LLC
FACILITY # 0044750
DECEMBER 31,2000

SCHEDULE 20 A

XVIII. A. STAFFING AND SALARY COSTS, Line 32

	# of Hrs. Worked	# of Hrs. Paid	Reporting Salaries	Average Wage
Staffing Coordinator	894	894	20,229	$ 22.63
Central Supply Clerk	1,856	1,996	20,752	$ 10.40
Care Plan Coordinator	1,216	1,343	27,769	$ 20.68
	3,966	4,233	68,750	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Norman Gross	Administrator	0.00%	$ 19,808
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 19,808

B. Administrative - Other

Description	Amount
Steve Jeremias	$ 51,094
Mark Weldler	44,654
TOTAL (agree to Schedule V, line 17, col. 3)	$ 95,748
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems	Computer Services	$ 18,340
Power Software Development	Computer Services	6,875
Paychex	Computer Services	4,388
Jacobs Health Care	Computer Services	4,882
RCN	Computer Services	260
Accu-Med Services	Computer Services	450
XO - DSL	Computer Services	25
American Express Tax & Bus. Serv.	Accounting	3,334
Sachnoff & Weaver Ltd.	Legal	1,114
Personnel Planners	U/C Consulting	1,348
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 41,016

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,280
Unemployment Compensation Insurance	46,490
FICA Taxes	143,103
Employee Health Insurance	98,945
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	6,946
Employee Physicals	521
Other Employee Benefits	3,685
TOTAL (agree to Schedule V, line 22, col.8)	$ 355,970

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
	N/A	
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	8,897
Health Care Worker Background Check	
(Indicate # of checks performed 16)	200
Secretary of State	200
Illinois Council on Long Term Care Dues	3,066
Miscellaneous Licenses	1,336
Miscellaneous Subscriptions	292
Miscellaneous Dues	1,718
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,909

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	133
Seminar Expense	960
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,093

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & Decorating	09/2000	108,663	3	$	$	$	$ 18,110	$ 36,221	$ 36,222	$ 18,110	$	$
2													
3													
4													
5													
6													
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16													
17													
18													
19													
20	TOTALS		$ 108,663		$	$	$	$ 18,110	$ 36,221	$ 36,222	$ 18,110	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 04/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $3,066**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,165** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **62,829**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **260**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **75%**
d. Have vehicle usage logs been maintained? **Adequate logs are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.